VALORACION DE HABITOS SALUDABLES

Nombre del paciente _____

Fecha de nacimiento _____ Fecha _____

Encierre en un círculo la respuesta que mejor describa los hábitos de alimentación y de actividad física promedio de su niño.

Mi hijo consume verduras y frutas:

0-1 veces al día | 1-2 veces al día | 3-4 veces al día | Más de 4 veces al día

Mi hijo come fuera:

Más de 4 veces por semana | 3-4 veces por semana | 1-2 veces por semana | 0-1 veces por semana

Mi hijo es activo:

No muy a menudo | Menos de 30 minutos al día | 30-60 minutos al día | Más de 60 minutos al día

Mi hijo toma bebidas azucaradas (gaseosas, té dulce, jugos, bebidas deportivas, otras bebidas con jugo):

Más de 3 al día | 2 al día | 1 al día | No muy a menudo

Mi hijo ve televisión o pasa tiempo en la computadora o en juegos de video:

Más de 2 horas al día | 1-2 horas al día | 30-60 minutos al día | No muy a menudo durante el día

¿Ha pensado ensayar nuevos hábitos saludables para su hijo o su familia?

No | Lo estoy pensando | Hemos tratado de hacer cambios saludables | Hemos estado haciendo cambios saludables

Si pudiera hacer un solo cambio saludable, ¿Cuál sería?

- ❑ Llene la mitad del plato con frutas y verduras
- ❑ Limite el tiempo frente a la pantalla a una hora
- ❑ Mantenga actividad durante 60 minutos
- ❑ Tome más agua y limite las bebidas azucaradas

Bright Futures.

8-10 years

Bright Futures Parent Supplemental Questionnaire Older Child/Early Adolescent Visits

Your Child's Name _____ Today's Date _____

Your Child's Age _____ Your Child's Sex (circle one): M F Your Child's Grade (in school) _____

Your Growing and Changing Child: Physical Growth and Development

1.	Does your child live in your home?	Yes	Sometimes	No
2.	Does your child receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?	No		Yes
3.	Does your child brush his teeth twice a day?	Yes		No
4.	Does your child floss once a day?	Yes		No
5.	Has your child seen a dentist in the past year?	Yes		No
6.	Does your child eat 5 or more helpings of fruits and vegetables each day?	Yes		No
7.	Does your child drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day?	Yes		No
8.	Does your child eat more than 1 fast food meal per week?	No	Sometimes	Yes
9.	Does your child do any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	Yes		No
10.	Does your child drink more than 1 soda or juice drink each day?	No		Yes
11.	Does your child watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	No		Yes
12.	Does your child have a problem with weight (such as underweight, overweight, anorexia, or bulimia)?	No		Yes
13.	Do you eat meals together as a family?	Yes		No
14.	Have you and your child discussed the physical and emotional changes that happen during puberty?	Yes		No
15.	Does your child have a TV in his bedroom?	No		Yes
16.	Have you talked to your child about waiting to have sex?	Yes		No
17.	For your daughter: Have she gotten her period?	Yes		No
18.	If yes, is she having any problems with or does she have any questions about her period?	No	Sometimes	Yes

School and Friends: Social and Academic Competence

19.	Does your child go to school?	Yes		No
20.	Is your child having any problems in school? Circle all that apply: grades worse than last year failing grades homework suspension this year fighting missing school other_____	No	Sometimes	Yes
21.	Is doing well in school important to you and your child?	Yes		No
22.	Do you know your child's friends and their families?	Yes		No
23.	Do you help your child see things from another person's point of view?	Yes		No
24.	Do you encourage your child to think through solutions rather than giving her the answers?	Yes		No

Violence and Injuries: Violence and Injury Prevention

25.	Does your child always wear a seat belt when riding in a car, truck, or van?	Yes	Sometimes	No
26.	Does your child have access to a gun at home or in places where she spends time?	No	Sometimes	Yes
27.	Does your child wear a helmet when he in-line skates, skateboards, bicycles, skis, or snowboards?	Yes	Sometimes	No
28.	Has your child had someone at home, school, or anywhere else who made her feel afraid, threatened her, or hurt her?	No		Yes
29.	Does your child wear protective gear when playing team sports?	No		Yes

Feeling Happy: Emotional Well-being

30.	Even with usual ups and downs, do you feel your child enjoys life?	Yes		No
31.	Do you praise your child when he does something good or learns something new?	Yes		No
32.	Do you spend time talking with your child every day?	Yes		No
33.	Do you clearly discuss with your child rules and family rules?	Yes		No
34.	Does your child worry a lot or feel overly stressed out?	No	Sometimes	Yes
35.	When your child is angry, does he do violent things?	No		Yes
36.	Does your child continue to remember, think, or talk about an unpleasant experience that happend in the past?	No		Yes

continued on page 3

Feeling Happy: Emotional Well-being continued from page 2

37.	During the past few weeks has your child often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though he has nothing to look forward to?	No		Yes
38.	Do you talk with your child about relationships and sex?	Yes		No
39.	Do you talk with your child about alcohol and drugs?	Yes		No
40.	Has your child ever seriously thought about killing himself, made a plan, or tried to kill himself?	No		Yes

Healthy Behavior Choices: Risk Reduction

41.	Does anyone you live with smoke cigarettes or cigars or chew tobacco?	No	Sometimes	Yes